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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MARIANNE O. DAVEDEIT,** **aka MARIANNE P. ORO,** **aka MARIANNE DELAPENA ORO** 7830 W. 83rd Street Playa Del Rey, CA 90293 Registered Nurse License No. 424802 Respondent.	Case No. 2011- 582 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (Board).

2. On or about April 30, 1988, the Board issued Registered Nurse License No. 424802 to Marianne O. Davedeit, aka Marianne P. Oro, aka Marianne Delapena Oro (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2013, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 118, subdivision (b), provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 provides that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2761 states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it. . . ."

7. Section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with

Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 2764 provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b), the Board may renew an expired license at any time within eight (8) years after the expiration.

REGULATORY PROVISION

9. California Code of Regulations, title 16, section 1442 states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

10. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

11. Ambien, a trade name for Zolpidem Tartrate, a nonbarbiturate hypnotic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(32), and categorized as a dangerous drug pursuant to section 4022.

12. Ativan, a trade name for Lorazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(16), and categorized as a dangerous drug pursuant to section 4022.

13. Hydrocodone, with trade names of Norco and Vicodin, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4), and categorized as a dangerous drug pursuant to section 4022.

14. Hydromorphone, with a trade name of Dilaudid, is an Opium derivative classified as a Schedule II Controlled Substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(k), and categorized as a dangerous drug pursuant to section 4022.

15. Morphine/Morphine Sulfate (extended release MS Contin), a narcotic substance, is a Schedule II controlled substance pursuant to Health and Safety Code Section 11055(b)(1)(M), and categorized as a dangerous drug pursuant to section 4022.

16. Percocet (Oxycontin), a brand name formation of oxycodone hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1), and is categorized as a dangerous drug pursuant to section 4022.

17. Propoxyphene (Darvocet and Darvon) is a combination drug containing acetaminophen, a Schedule IV controlled substances pursuant to Health and Safety Code section 11057(c)(2), and categorized as a dangerous drug pursuant to section 4022.

18. Oxazepam (Serax), a benzodiazepine, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(b)(2), and categorized as a dangerous drug pursuant to section 4022.

19. Oxycodone, with a trade name of Percolone, is a synthetic opioid analgesic, a schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1), and categorized as a dangerous drug pursuant to section 4022.

20. Restoril, a brand name for Temazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057(d)(29), and categorized as a dangerous drug pursuant to section 4022.

FIRST CAUSE FOR DISCIPLINE

(False Records)

21. Respondent is subject to disciplinary action under section 2761, subdivision (a), and 2762, subdivision (e), on the grounds of unprofessional conduct, in that on or about August 4, 2006, through September 7, 2006, while on duty as a registered nurse at Saint John's Health Center, Santa Monica, California (SJHC), Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other record pertaining to controlled substances for patients, as follows:

a. In or about September 2006, SJHC administration conducted a random audit of Respondent's controlled substance and dangerous drug withdrawals from the hospital's Omnicell[1] dispensary. On or about randomly chosen days of August 4, 6, 7 and 11, 2006, and September 4, 5, 6 and 7, 2006, Respondent's Omnicell transactions identified over 30 medication discrepancies involving 11 patients, and no record was found that she either administered or wasted the medications.

b. **Patient CR.**

1) On or about August 4, 2006, physician's medication orders were Percocet 5/325mg tablet every 3 hours as needed for pain, and Percocet 5/325mg tablet every 3 hours as needed for severe pain.

2) On or about August 4, 2006, at 10:36 pm, Respondent withdrew two (2) Percocet 5/325mg tablets. Respondent failed to document administration and / or wastage of two (2) Percocet tablets on the patient's Medication administration Record (MAR) and / or Nurse's

[1] "Omnicell" is a computerized single dose medication dispensing machine. The user enters a unique user identified, password and / or thumbprint scan in order to access and dispense medication from the machine. The machine records the user name, patient name, medication, dose, date and time of the dispensing/withdrawal. The Omnicell is integrated with hospital pharmacy inventory management systems.

Notes.

3) Respondent failed to account for two (2) Percocet 5/325 mg tablets in any hospital record.

c. **Patient BK**.

1) On or about August 6 and 7, 2006, physician's medication orders were Percocet 5/325mg tablet every 3 hours as needed for pain, and two (2) Percocet 5/325mg tablets every 3 hours as needed for severe pain.

2) On or about August 6, 2006, at 10:22 pm, Respondent withdrew two (2) Percocet 5/325mg tablets and failed to document administration and / or wastage of the two (2) Percocet tablets on the patient's MAR and / or Nurse's Notes.

3) On or about August 7, 2006, at 01:12 am, Respondent withdrew two (2) Percocet 5/325mg tablets and failed to document administration and / or wastage of the two (2) Percocet tablets on the patient's MAR and / or Nurse's Notes.

4) On or about August 7, 2006, at 5:39 am, Respondent withdrew two (2) Percocet 5/325mg tablets. At 6:00 am, Respondent documented administration of one (1) Percocet tablet on the patient's MAR and failed to document administration and / or wastage of the second one (1) Percocet tablet on the patient's MAR and / or Nurse's Notes.

5) Respondent failed to account for five (5) Percocet 5/325 mg tablets in any hospital record.

d. **Patient TF**.

1) On or about August 11, 2006, physician's medication orders were Percocet tablets every 3 hours as needed for pain, Vicodin 1 tablet every 3 hours as needed for mild pain, and Vicodin 2 tablets every 3 hours as needed for moderate pain.

2) On or about August 11, 2006, at 12:06 am, Respondent withdrew two (2) Percocet 5/325 mg tablets and failed to document administration and / or wastage of the two (2) Percocet tablets on the patient's MAR and / or Nurse's Notes.

3) On or about August 11, 2006, at 2:30 am, Respondent withdrew two (2) Vicodin 5/500 mg tablets and failed to document administration and / or wastage of the two (2)

Vicodin tablets on the patient's MAR and / or Nurse's Notes.

4) Respondent failed to account for two (2) Percocet 5/325 mg tablets and two (2) Vicodin 5/500 mg tablets in any hospital record.

e. **Patient EP**.

1) On or about August 4, 2006, physician's medication orders were Darvocet N-100 (1) tablet every 4 hours as needed for severe pain, and Darvon 65mg (1) capsule every 4 hours as needed for severe pain.

2) On or about August 4, 2006, at 05:49 am, Respondent withdrew one (1) Darvocet N-100 tablet and failed to document administration and / or wastage of the one (1) Darvocet N-100 tablet on the patient's MAR and / or Nurse's Notes.

3) On or about August 4, 2006, at 5:49 am, Respondent withdrew one (1) Darvon 65mg capsule and failed to document administration and / or wastage of the one (1) Darvon 65mg capsule on the patient's MAR and / or Nurse's Notes.

4) On or about August 4, 2006, at 08:35 pm.., Respondent withdrew one (1) Darvocet N-100 tablet and failed to document administration and / or wastage of the one (1) Darvocet N-100 tablet on the patient's MAR and / or Nurse's Notes.

5) On or about August 4, 2006, at 8:35 pm, Respondent withdrew one (1) Darvon 65 mg capsule and failed to document administration and / or wastage of the one (1) Darvon 65mg capsule N-100 tablets on the patient's MAR and / or Nurse's

6) Respondent failed to account for two (2) Darvocet N-100 tablets and two (2) Darvon capsules in any hospital record.

f. **Patient KB**.

1) On or about September 4, 5, and 6, 2006, physician's medication orders were Oxycodone (Percolone) 10mg every 3 hours as needed for pain, Ambien 10mg as needed for insomnia, (2) Norco 10/325 tablets every 3 hours as needed for severe pain, Morphine Sulfate 4mg IV every 3 hours as needed for pain, and Morphine Sulfate 6mg IV every 3 hours as needed for severe pain.

2) On or about September 4, 2006, at 6:06 am, Respondent withdrew two (2) 15mg MS

Contin tablets. Respondent recorded on the patient's MAR administration of one (1) 15mg MS Contin, and failed to document administration and / or wastage of one (1) 15mg MS Contin on the patient's MAR and / or Nurse's Notes.

3) On or about September 5, 2006, at 12:49 pm, Respondent withdrew two (2) Percolone (Oxycodone) 5mg tablets and failed to document administration and / or wastage of the two (2) Percolone tablets.

4) On or about September 5, 2006, at 3:52 pm, Respondent withdrew two (2) Percolone (Oxycodone) 5mg tablets and failed to document administration and / or wastage of the two (2) Percolone tablets.

5) On or about September 6, 2006, at 12:04 a.m., Respondent withdrew two (2) Percolone (Oxycodone) 5mg tablets and failed to document administration and / or wastage of the two (2) Percolone tablets.

6) On or about September 6, 2006, at 2:56 a.m., Respondent withdrew two (2) Percolone (Oxycodone) 5mg tablets. Respondent charted as administering two (2) Percolone (Oxycodone) 5mg tablets on September 6, 2006, at 2:00 a.m. Respondent charted as administering two (2) tablets of Percolone (Oxycodone) 5mg to patient "KB" prior to actually removing said medications from the medication chart.

7) On or about September 6, 2006, at 2:18 a.m., Respondent withdrew two (2) Norco 10/325mg tablets. Respondent charted as administering two (2) Norco 10/325mg tablets on September 6, 2006, at 2:00 a.m. Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "KB" prior to actually removing said medications from the medication chart.

8) On or about September 6, 2006, at 6:33 a.m., Respondent withdrew two (2) Percolone (Oxycodone) 5mg tablets. Respondent charted as administering two (2) Percolone (Oxycodone) 5mg tablets on September 6, 2006, at 6:20 a.m. Respondent charted as administering two (2) tablets of Percolone (Oxycodone) 5mg to patient "KB" prior to actually removing said medications from the medication chart.

9) On or about September 6, 2006, at 4:07 pm, Respondent withdrew one (1) Morphine

8mg syringe and failed to document administration and / or wastage of the 8mg Morphine syringe.

10) Respondent failed to account for one 15mg MsContin tablets, six (6) 5mg Percolone tablets, and one (1) 8mg Morphine syringe in any hospital record.

11) Respondent charted as administering two (2) doses of Percolone Oxycodone) 5mg tablets to patient "KB" on September 6, 2006 at 2:00 a.m. and another two (2) doses of Percolone Oxycodone) 5mg tablets at 6:20 a.m. prior to actually removing said medications from the medication chart.

12) Further, Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "KB" on September 6, 2006 at 2:00 a.m. prior to actually removing said medications from the medication chart.

g. **Patient JN**.

1) Physician's medication orders were as follows:

i. September 4, 2006, at 8:30 am, Oxycontin 60mg by mouth, twice daily, Norco and Vicodin discontinued, and Percolone 5mg by mouth every 4 hours as needed for breakthrough pain.

ii. September 4, 2006, at 5:30 pm, Dilaudid IV 2mg every 2 hours as needed for breakthrough pain, and Norco 10/325 mg 2 by mouth every 4 hours as needed for breakthrough pain.

2) On or about September 4, 2006, at 4:27 am, Respondent withdrew two (2) Vicodin 5/500 mg tablets and failed to document administration and / or wastage of the two Vicodin tablets.

3) On or about September 4, 2006, at 10:00 pm, Respondent withdrew two (2) Ambien 5mg tablets and failed to document administration and / or wastage of the two (2) 5mg Ambien tablets.

4) On or about September 4, 2002, at 10:22 pm, Respondent withdrew one (1) 5mg Percolone (Oxycodone) tablet and failed to document administration and / or wastage of the Percolone tablet.

5) On or about September 5, 2006, at 2:25 am, Respondent withdrew one (1) Percolone 5mg tablet. At 1:00 am, a time prior to the Omnicell's recorded withdrawal by Respondent, Respondent documented administration of one (1) Percolone 5mg tablet.

6) On or about September 5, 2006, at 4:50 am, Respondent documented administration of Hydromorphone 2mg IV push, and the Omnicell failed to record her withdrawal of the one (1) Hydromorphone 2mg vial.

7) On or about September 5, 2006, at 8:26 pm, Respondent withdrew two (2) Ambien 5mg tablets and failed to document administration and / or wastage of the two (2) Ambien tablets.

8) On or about September 6, 2006, at 12:05 am, Respondent withdrew two (2) Norco 10/325 mg tablets and failed to document administration and / or wastage of the two (2) Norco tablets.

9) Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "JN" on September 6, 2006 at 6:30 a.m. prior to actually removing said medications from the medication chart at 6:32 a.m.

10) On or about September 6, 2006, at 9:44 pm, Respondent withdrew two (2) Ambien 5mg tablets and failed to document administration and / or wastage of the two (2) Ambien tablets.

11) Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "JN" on September 5, 2006 at 9:00 p.m., yet there is no record that Respondent removed said medications from the medication chart at or about 9:00 p.m.

12) Respondent failed to account for two (2) Vicodin 5/500mg tablets, six (6) Ambien 5mg tablets, and two (2) Norco 10/325 tablets in any hospital record.

13) Further, Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "JN" on September 6, 2006 at 6:30 a.m., prior to actually removing said medications from the medication chart.

14) Respondent charted as administering two (2) tablets of Norco 10/325mg tablets to patient "JN" on September 5, 2006 at 9:00 p.m., yet there is no record that Respondent removed said medications from the medication chart.

h. **Patient FE.**

1) On or about September 6, 2006, physician's medication orders were Morphine Sulfate 2mg IV every 6 hours as needed for pain, one (1) Percocet tablet every 3 hours as needed for pain, one (1) Vicodin 5/500mg tablet every 3 hours as needed for mild pain, and two (2) Vicodin 5/500mg tablets every 3 hours as needed for moderate pain.

2) On or about September 6, 2006, at 6:14 am, Respondent withdrew one (1) Oxycodone/Apap 5/325mg tablet and failed to document administration and / or wastage of the one Oxycodone/Apap tablet.

3) On or about September 6, 2006, at 4:08 pm, Respondent withdrew one (1) Morphine 2mg syringe and failed to document administration and / or wastage of the Morphine syringe.

4) On or about September 6, 2006, at 11:31 pm, Respondent withdrew two (2) Vicodin 5/325 mg tablets and failed to document administration and / or wastage of the two (2) Vicodin tablets.

5) Respondent failed to account for one (1) Oxycodone/Apap tablet, one (1) Morphine 2mg syringe, and two (2) Vicodin 5/325mg tablets in any hospital record.

i. **Patient DB.**

1) On or about September 4, 5 and 6, 2006, physician's medication orders were Hydromorphone/Apap (Norco) 10/325mg (1) tablet every 3 hours as needed for pain, and Lorazepam (Ativan) 1mg IV every 6 hours as needed for agitation.

2) On or about September 4, 2006, at 12:13 am, Respondent withdrew one (1) Norco 10/325 tablet and failed to document administration and / or wastage of the one (1) Norco tablet.

3) On or about September 4, 2006, at 4:28 am, Respondent withdrew one (1) Norco 10/325 tablet and failed to document administration and / or wastage of the one (1) Norco tablet.

4) On or about September 5, 2006, at 12:50 am, Respondent withdrew one (1) Norco 10/325 tablet and failed to document administration and / or wastage of the one (1) Norco tablet.

15) On or about September 5, 2006, at 5:00 am, Respondent documented administration of one (1) Ativan 2mg/1ml vial, yet there is no record that Respondent removed said medications from the medication chart at or about 5:00 p.m.

16) On or about September 5, 2006, at 8:00 pm, Respondent documented administration of one (1) Ativan 2mg/1ml vial, yet there is no record that Respondent removed said medications from the medication chart at or about 8:00 p.m.

5) On or about September 6, 2006, at 12:04 am, Respondent withdrew one (1) Ativan 2mg/1ml vial and failed to document administration and / or wastage of the one (1) Ativan 2mg/1ml vial.

6) On or about September 6, 2006, at 12:06 am, Respondent withdrew one (1) Norco 10/325 tablet and failed to document administration and / or wastage of the one (1) Norco tablet.

7) On or about September 6, 2006, at 2:55 am, Respondent withdrew one (1) Norco 10/325 tablet and failed to document administration and / or wastage of the one (1) Norco tablet.

8) Respondent failed to account for five (5) Norco 10/325 mg tablets, and one Ativan 2mg/1ml vial in any hospital record.

17) On or about September 5, 2006, at 5:00 am Respondent documented administration of one (1) Ativan 2mg/1ml vial, yet there is no record that Respondent removed said medications from the medication chart at or about 5:00 p.m.

18) On or about September 5, 2006, at 8:00 am Respondent documented administration of one (1) Ativan 2mg/1ml vial, yet there is no record that Respondent removed said medications from the medication chart at or about 8:00 p.m.

j. **Patient CD**.

1) On or about September 6 and 7, 2006, physician's medication orders were MS Contin 60mg every 8 hours, and Ambien 10mg at bedtime, as needed.

2) On or about September 6, 2006, at 8:00 pm, Respondent withdrew two (2) MS Contin 60mg tablets and failed to document administration and / or wastage of the two (2) MS Contin 60mg tablets.

3) On or about September 6, 2006, at 8:01 pm, Respondent withdrew one (1) MS Contin 15mg tablet and failed to document administration and / or wastage of the one (1) MS Contin 15mg tablet.

4) On or about September 6, 2006, at 8:01 pm, Respondent withdrew one (1) MS Contin

60mg tablet and failed to document administration and / or wastage of the one (1) MS Contin 60mg tablet.

5) On or about September 7, 2006, at 12:52 am, Respondent withdrew two (2) Ambien 5mg tablets and failed to document administration and / or wastage of the two (2) Ambien tablets.

6) On or about September 7, 2006, at 5:06 am, Respondent withdrew one (1) MS Contin 15mg tablet and failed to document administration and / or wastage of the one (1) MS Contin 15mg tablet.

7) Respondent failed to account for three (3) MS Contin 60 mg tablets, two MS Contin 15mg tablets, and two (2) Ambien 5mg tablets in any hospital record.

8) Further, Respondent charted as administering one (1) tablet of MS Contin 60mg on September 7, 2006, prior to actually removing said medication from the medication chart at 5:06 a.m.

k. **Patient MR**.

1) On or about September 4, 2006, physician's medication orders were Vicodin 5/500mg 2 tablets every 3 hours as needed for moderate pain, Davocet N-100mg 1 tablet every 3 hours as needed for mild pain, and Darvocet N-100mg 2 tablets every 3 hours as needed for moderate pain.

2) On or about September 4, 2006, at 12:12 am, Respondent withdrew two (2) Vicodin 5/500mg tablets and failed to document administration and / or wastage of the two (2) Vicodin 5/500mg tablets.

3) On or about September 4, 2006, at 2:48 am, Respondent withdrew two (2) Darvocet 100mg tablets and failed to document administration and / or wastage of the two (2) Darvocet tablets.

4) On or about September 4, 2006, at 4:28 am, Respondent withdrew two (2) Vicodin 5/500mg tablets and failed to document administration and / or wastage of the two (2) Vicodin 5/500mg tablets.

5) Respondent failed to account for four (4) Vicodin 5/500mg tablets, and two (2) Darvocet 100mg tablets in any hospital record.

l. **Patient EM**.

1) On or about September 6 and 7, 2006, physician's medication orders were Restoril 15mg capsule at bedtime, as needed, and Vicodin 5/500mg 1 tablet every 4 hours as needed for pain.

2) On or about September 6, 2006, at 9:44 pm, Respondent withdrew one (1) Restoril 15mg capsule and failed to document administration and / or wastage of the one (1) Restoril capsule.

3) On or about September 7, 2006, at 12:51 am, Respondent withdrew one (1) Vicodin 5/500mg tablet and failed to document administration and / or wastage of the one (1) Vicodin tablet. Furthermore, Patient EM documented denial of receiving the one (1) Vicodin tablet withdrawn by Respondent for administration to him.

4) Respondent failed to account for one (1) Restoril 15mg capsule, and one (1) Vicodin 5/5/00mg tablet in any hospital record.

5) Respondent charted as administering one (1) Vicodin 5/500mg tablet on September 6, 2006 at 9:00 p.m., prior to actually removing said medication from the medication chart at 9:44 p.m.

6) Further, Respondent charted as administering one (1) Vicodin 5/500mg tablet on September 7, 2006 at 4:30 a.m., prior to actually removing said medication from the medication chart at 5:08 a.m.

SECOND CAUSE FOR DISCIPLINE

(Illegally Obtain/Possess Controlled Substances / Dangerous Drugs)

22. Respondent is subject to disciplinary action under sections 2761, subdivision (a), and 2762, subdivision (a), on the grounds of unprofessional conduct, in that on or between August 4, 2006 and September 7, 2006, while on duty as a registered nurse at SJHC, Respondent obtained or possessed in violation of law controlled substances and dangerous drugs. Complaint refers to and by this reference incorporates the allegations set forth above in paragraph 21, inclusive, as though set forth fully.

THIRD CAUSE FOR DISCIPLINE

(Dangerous Use)

23. Respondent is subject to disciplinary action under sections 2761, subdivision (a), and 2762, subdivision (b), on the grounds of unprofessional conduct, in that on or between August 4, 2006, through on or about September 7, 2006, while employed as a registered nurse at SJMC, Respondent dangerously used controlled substances and dangerous drugs to an extent or in a manner dangerous or injurious to herself or others and / or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by her license, as follows:

1) On or between August 4, 2006, and September 7, 2006, Respondent obtained controlled substances and dangerous drugs for patients and failed to document their administration, and / or wastage on hospital records.

2) On or about September 11, 2006, Respondent tested positive for Oxazepam (Serax) and Propoxyphene (Darvon) without having valid prescriptions.

3) On or about September 19, 2006, Respondent admitted to taking medications from hospital stores.

4) On or about September 19, 2006, Respondent's employment with SJMC was terminated.

Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 21 - 22, inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

24. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that while employed as a registered nurse at SJMC, Respondent demonstrated acts of gross negligence, an extreme departure of repeated acts, as follows:

1) Respondent failed to provide nursing care that ensures no harm to come to one's patients due to failure to properly assess, treat, and / or withhold pain medications without cause and / or for personal reasons.

2) Respondent obtained and / or possessed controlled substances in violation of law.

3) Respondent tested positive for Oxazepam (Serax) and Propoxyphene (Darvon) without having valid prescriptions.

Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 21 - 23, inclusive, as though set forth fully.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

25. Respondent is subject to disciplinary action under section 2761, subdivision (a), in that Respondent committed acts of unprofessional conduct. Complaint refers to and by this reference incorporates the allegations set forth above in paragraphs 21 - 24, inclusive, as though set forth fully.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

26. Respondent is subject to disciplinary action under section 2761, subdivision (a), on the grounds of unprofessional conduct, in that on or about February 17, 2000, Respondent was charged with one count of violating Penal Code section 484(a) [petty theft[2]] in the criminal proceeding entitled *The People of the State of California v. Marianne Oro Daveditt* (Super. Ct. Los Angeles County, 2000, Case No. 0CU00295). On April 5, 2002, Court ordered Complaint be amended to add violation of Penal Code section 415 [disturbing the peace]. On April 5, 2002, after pleading *nolo contendre,* Respondent was convicted of one count of violating Penal Code section 415 [disturbing the peace]. Respondent was fined.

27. The circumstances of the conviction are that on or about January 15, 2000, Respondent stole, took, and carried away the personal property of another[3], to wit: COSTCO store in Culver City, California. Respondent was arrested in the COSTCO store loss prevention agent, Adrain Padilla and subsequently arrested by the Culver City Police Department.

[2] A crime of dishonesty and moral turpitude
[3] An act involving dishonesty

DISCIPLINE CONSIDERATIONS

28. To determine the degree of discipline, Complainant alleges that on or about September 27, 1993, in a prior disciplinary action entitled *In the Matter of the Accusation Against Marianne P. Oro aka Marianne Delapena Oro*, Case No. 89-92, before the Board of Registered Nursing, Respondent's license was revoked, the revocation was immediately stayed, and she was placed on probation for three (3) years subject to certain terms and conditions. The Decision is attached herein as Exhibit "A" and incorporated herein in full as if set forth fully.

29. On or about May 23, 1989, Respondent was convicted with one count of violating Penal Code sections 182 and 134 [conspiracy to prepare false documents[4]] in the criminal proceeding entitled *The People of the State of California v. Marianne Oro Daveditt* (Super. Ct. Los Angeles County, 1989, Case No. A973111). Said crime of conspiracy to prepare false documents is substantially related to the qualifications, functions, and duties of a Board licensee. As a result of the conviction, the imposition of sentence was suspended and Respondent was placed on probation for three (3) years on condition that she performs a minimum of one hundred (100) hours of community service at the direction of the Probation Department.

30. The circumstances of the disciplinary action are that on or about April of 1988, Respondent was asked by her twin sister, Marilou P. Oro, if Respondent knew anyone for whom Marilou could take a nurse's licensing examination in exchange for money. Respondent gave the name and telephone number of her sister Marilou to a nurse's aide named Pira who had earlier failed the examination for a licensed vocational nurse's license. Such conduct involved an act of dishonesty.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 424802, issued to Marianne O. Davedeit;

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[4] A felony and crime involving moral turpitude.

2. Ordering Marianne O. Davedeit to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: July 27, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT "A"

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Acusation Against:	
MARIANNE P. ORO aka Marianne Delapena Oro 15518 South Broadway Street Gardena, CA 90248,	Case No. 89-92 OAH No. L-59103
License No. E-424802,	
Respondent.	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on September 27, 1993.

IT IS SO ORDERED this 27th day of August, 1993.

BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By Harriett W. Clark
HARRIETT W. CLARK, Esq.
President

lf

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	
MARIANNE P. ORO aka MARIANNE DELAPENA ORO 15518 South Broadway Street Gardena, CA 90248,	No. 89-82 L-59103
License No. E-424802,	
Respondent.	

PROPOSED DECISION

This matter was heard by Vincent Nafarrete, Administrative Law Judge of the Office of Administrative Hearings, at Los Angeles, California, on March 30, 1993. Complainant was represented by Earl R. Plowman, Deputy Attorney General. Respondent was present during the hearing and represented by Gerald Klausner, Attorney at Law.

For purposes of hearing, this matter was consolidated and heard together with the Matter of the First Amended Accusation against Marianne P. Oro, aka Marianne Delapena Oro, case no. 5171, L-59102, and the Matter of the First Amended Accusation against Marilou P. Oro, case no. 5164, L-59105, before the Board of Vocational Nurse and Psychiatric Technician Examiners, as well as the Matter of the First Amended Accusation against Marilou P. Oro, case no. 89-73, L-59104, before the Board of Registered Nursing.

Oral and documentary evidence having been received and the matter submitted for decision, the Administrative Law Judge finds as follows:

FINDINGS OF FACT

1. The Administrative Law Judge takes official notice that, on November 21, 1989, the First Amended Accusation was made and issued by Catherine M. Puri, R.N., Ph.D., solely in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs, State of California (hereafter Board).

2. On September 25, 1985, the Board issued registered nurse's license no. 424802 to Marianne P. Oro, also known as Marianne O. Davedeit and Marianne P. Oro Davedeit (hereafter respondent). Said license expires on June 30, 1993, and is in full force and effect.

3. (A) On May 23, 1989, before the Superior Court of California, County of Los Angeles, State of California, in People v. Marianne Delapena Oro, case no. A973111, respondent was convicted on her plea of nolo contendere of violating Penal Code Sections 182 and 134 (conspiracy to prepare false documents), a felony and crime involving moral turpitude.

(B) As a result of the conviction, imposition of sentence was suspended and respondent was placed on probation for three years on condition that she perform a minimum of 100 hours of community service at the direction of the Probation Department.

(C) Said crime of conspiracy to prepare false documents is substantially related to the qualifications, functions, and duties of a Board licensee. Honesty and integrity are qualities required of a registered nurse.

4. The facts and circumstances of respondent's offense are as follows:

a. In early April 1988, respondent was asked by her twin sister Marilou P. Oro if respondent knew anyone for whom Marilou P. Oro could take a nurse's licensing examination for money. Marilou P. Oro told respondent she desperately needed money due to financial and gambling problems. Marilou P. Oro was in the midst of dissolving her marriage, her house was in foreclosure, and she was pregnant with her third child. At all times relevant herein, Marilou P. Oro was licensed as a registered nurse and held an expired vocational nurse's license. Respondent felt sorry for her sister and gave her the name of Esmat Pira (hereafter Pira).

b. Respondent worked with Pira at the Berkley East Convalescent Hospital in Santa Monica where respondent was employed as a nursing supervisor and Pira was employed as a nurse's aide. Respondent was aware that Pira had earlier failed an examination for a licensed vocational nurse's license. She gave Pira the name and telephone number of her sister Marilou P. Oro.

c. On or about April 14, 1988, Marilou P. Oro met Pira in Santa Monica and together they went to Pira's apartment. On said date, the two of them entered into an agreement whereby Marilou P. Oro was to impersonate Pira and take on behalf of Pira the National Council Licensure Examination for Practical Nurses

(hereafter licensing examination), which was scheduled to be given on April 19, 1988, at the Los Angeles Convention Center, and whereby Pira was to pay Marilou P. Oro the sum of $1,000.00.

d. On or about April 14, 1988, Marilou P. Oro and Pira went to the latter's bank. Pira withdrew $1,000.00 and gave said sum to Marilou P. Oro. Marilou P. Oro asked for and received Pira's admission card to said licensing examination.

e. On April 19, 1988, at the Los Angeles Convention Center, Marilou P. Oro caused her photograph to be attached to Pira's examination admission card. Thereupon, Marilou P. Oro impersonated Pira and took said licensing examination for and on behalf of Pira. Subsequently, Pira received a passing score for said licensing examination.

f. On April 19, 1988, said licensing examination constituted a licensing examination which the Board of Vocational Nurse and Psychiatric Technician Examiners required an applicant to pass for issuance of a license to practice as a licensed vocational nurse.

5. (A) After introducing Marilou P. Oro and Pira to each other, respondent took no further action and had no further part in their scheme to subvert said licensing examination. Respondent did not impersonate an examinee or subvert a licensing examination. Respondent did not arrange or make arrangements for her sister Marilou P. Oro to impersonate examinee Pira or to take said licensing examination for Pira.

(B) Marilou P. Oro and Pira made their own agreement and arrangements to subvert said licensing examination without further collusion from respondent. Respondent did not receive any remuneration from their scheme of subversion. She felt sorry for her sister and wanted to help her.

6. (A) It was not established that respondent attempted to subvert said licensing examination by arranging for Marilou P. Oro to impersonate Pira in order to take said licensing examination for Pira at the Los Angeles Convention Center on April 19, 1988, or any other date.

(B) It was not established that respondent engaged in conduct which subverted a licensing examination or attempted to subvert a licensing examination in violation of Business and Professions Code Section 123.

7. (A) It was not established that respondent arranged for Marilou P. Oro to impersonate Pira in order to take said licensing examination for Pira at the Los Angeles Convention Center on April 19, 1988, or any other date.

(B) It was not established that respondent impersonated any other person or permitted or aided any person in any manner to impersonate respondent in connection with any examination for a license in violation of Business and Professions Code Section 2797.

8. Respondent demonstrates remorse for her conduct in introducing the parties to the scheme to one another. She recognizes that her conduct was wrong and demonstrates poor judgment.

9. Respondent completed the 100 hours of community service. She has successfully completed all of the terms and conditions of said probation and is no longer on probation for her offense.

10. On August 5, 1992, a Superior Court Judge granted respondent's petition expunging her conviction under Penal Code Section 1203.4. As a result, respondent's plea was set aside and the criminal complaint was dismissed.

11. Respondent has no other convictions or prior disciplinary history.

12. Respondent received a bachelor of science degree in nursing from the Manila Doctor's College of Nursing and Liberal Arts in the Philippines in April 1980.

13. Respondent has been a registered nurse for five years. Respondent has also held a vocational nurse's license issued by the Board of Vocational Nurse and Psychiatric Technician Examiners since September 24, 1985. Said vocational nurse's license is inactive at the present time.

14. From July 1987 through April 1988, respondent worked as a licensed vocational nurse at the Berkley East Convalescent Hospital. She also worked at Country Villa Westwood in Los Angeles as a licensed vocational nurse and registered nurse.

15. Beginning in August 1988 and continuing to the present time, respondent has been employed as a registered nurse at the Santa Monica Hospital Medical Center. During this approximate five year period at said hospital, respondent has been working as a charge or head nurse in the Center for Extended Care, a skilled nursing facility. Respondent is well regarded as a competent, reliable, dedicated, and trustworthy charge nurse by doctors and the administrator of said facility.

16. Respondent is 35 years old. For the past six years, she has been married to a graphic artist and lives with

him in Marina Del Rey. Respondent also provides support to her two children from a former marriage.

17. Respondent has not seen her sister Marilou P. Oro in the last 18 months. She believes that Pira has returned to her native country of Iran.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

CONCLUSIONS OF LAW

1. Grounds exist to revoke or suspend respondent's registered nurse's license pursuant to Business and Professions Code Sections 490 and 2761(f), in that respondent has been convicted of a crime involving moral turpitude, which is substantially related to the qualifications, functions, and duties of a registered nurse, as set forth in Findings 3 - 4 above.

2. Grounds do not exist to revoke or suspend respondent's registered nurse's license pursuant to Business and Professions Code Section 496, in that it was not established that respondent attempted to subvert a licensing examination in violation of Business and Professions Code Section 123, as set forth in Findings 5 - 6 above.

3. Grounds do not exist to revoke or suspend respondent's registered nurse's license pursuant to Business and Professions Code Section 2761(d), in that it was not established that respondent violated Business and Professions Code Section 2797, as set forth in Findings 5 - 7 above.

4. Defenses. Respondent did not establish that she was disadvantaged or prejudiced by any delay in the adjudication of this disciplinary matter . Accordingly, respondent's motion to dismiss the First Amended Accusation on the grounds of laches is denied.

5. Mitigation/Rehabilitation. Respondent played a minor, albeit essential, role in her sister's and co-worker's subversion of a nurse's licensing examination. Said parties would not have known of each other's needs or made their arrangements to subvert said licensing examination without respondent. Nevertheless, respondent did not herself impersonate any examinee or subvert any licensing examination. She did not

profit from their illegal scheme. Respondent introduced her sister and her co-worker to each other by giving them each other's names and a telephone number.

Furthermore, respondent demonstrates remorse for her conduct. She has also completed probation for her conviction and has had her conviction expunged pursuant to Penal Code Section 1203.4. Since her offense, respondent has been employed for almost five years as a charge nurse at Santa Monica Hospital Medical Center and has performed her nursing duties in a competent and skillful manner. Respondent has no other convictions or prior disciplinary history.

Accordingly, while disciplinary action is warranted, revocation of respondent's registered nurse's license is too harsh of a penalty under the circumstances of this matter. Respondent showed bad judgment as well as disregard for the law and the integrity of the nurses's licensing process by helping her twin sister. She does not, however, present a danger to the public interest and welfare, based on Findings 5 and 8 - 17 above.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

ORDER

Registered nurse's license no. 424802 and licensing rights issued by the Board of Registered Nursing to respondent Marianne P. Oro, also known as Marianne Delapena Oro, Marianne P. Oro Davedeit, and Marianne O. Davedeit, are revoked, based on Conclusions of Law no. 1; provided, however, said order of revocation shall be stayed and respondent placed on probation to the Board for three (3) years under the following terms and conditions:

1. Respondent shall obey all federal, state, and local laws as well as the rules and regulations of the Board of Registered Nursing governing the practice of nursing in California. In the event of any violation of law by respondent, she shall report and provide a detailed account of all such violations of law to the Board in writing within 72 hours of such occurrence.

2. Respondent shall fully comply with the terms and conditions of the probation program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of respondent's compliance with the program.

3. During the period of probation, respondent shall appear in person at interviews or meetings as directed by the Board or its designated representatives.

4. Any periods of residency or practice of nursing outside of California will not apply to the reduction of said probationary term. Respondent shall provide written notice to the Board within 15 days of any change of residency or practice outside of this state.

5. During the period of probation, respondent shall submit written reports or declarations and verifications of actions under penalty of perjury when required by the Board. Said declarations shall contain statements pertinent to respondent's compliance with all terms and conditions of the Board's probation program. Respondent shall execute and sign immediately upon receipt all release of information forms as required by the Board or its representatives.

6. Respondent shall engage in the practice of professional nursing in California for a minimum of 24 hours per week (as determined by the Board) for six consecutive months during the period of probation. As provided by Business and Professions Code Section 2732, respondent shall not engage in the practice of registered nursing without holding a license which is in active status.

7. Respondent shall inform the Board prior to the commencement of work of the name of each employer or agency for which she provides nursing services. Respondent shall inform her employer of the reason for and the terms of conditions of probation as well as provide a copy of the Board's decision and order to her employer and immediate supervisor. Respondent shall cause her employer to submit performance evaluations and other reports as requested by the Board. Respondent shall also notify the Board in writing within 72 hours after termination of any nursing employment. Any notification of termination of employment given to the Board shall contain a full explanation and reasons for such termination.

8. Respondent shall practice nursing under the minimum supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing. Respondent may work as a charge or head nurse.

9. Respondent may also work for a nurses' registry; temporary nurses' agency; home care agency; in-house nursing pool; as a nursing supervisor; as a faculty member in an approved school of nursing; or as an instructor in a Board-approved continuing education program.

10. Respondent shall take and successfully complete a course in ethics. Said course shall be in addition to any course(s) required for license renewal. Within sixty (60) days of the effective date of this Decision, the Board will advise respondent of the number of course hours required to meet this requirement. Within thirty (30) days thereafter, respondent shall submit a plan to comply with this requirement. The Board must first approve such plan before respondent may enroll in any course of study. Respondent shall successfully complete said required remedial course no later than the end of the first year of probation. Upon successful completion of said course, respondent shall immediately cause the instructor to furnish proof of completion to the Board.

11. In the event that respondent violates any term or condition of probation, the Board, after giving respondent proper notice and an opportunity to be heard, may set aside the stay order and impose the disciplinary order set forth hereinabove. If, during the period of probation, an accusation is filed against respondent's license, the probationary period shall be automatically extended and shall not expire until the accusation has been adjudicated by the Board.

12. Upon successful completion of probation, respondent's license will be full restored.

DATED: May 6, 1993

V. Navarrete

VINCENT NAVARRETE
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	NO. 89-92
MARIANNE P. ORO aka MARIANNE DELAPENA ORO 15518 So. Broadway Street Gardena, CA 90248 License No. E 424802 Respondent.	FIRST AMENDED ACCUSATION

Catherine M. Puri, R.N., Ph.D., for causes for discipline, alleges:

1. Complainant Catherine M. Puri, R.N., Ph.D., makes and files this first amended accusation in her official capacity as Executive Officer, Board of Registered Nursing, Department of Consumer Affairs. This first amended accusation supersedes and replaces nunc pro tunc the accusation heretofore filed.

2. On April 30, 1988, the Board of Registered Nursing issued registered nurse license number E 424802 to

Marianne P. Oro, also known as Marianne Delapena Oro. The license was in full force and effect at all times pertinent herein and has been renewed through June 30, 1991.

3. Under Business and Professions Code section 2750, the Board of Registered Nursing may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 of the Nursing Practice Act.

Under Business and Professions Code section 496, the board may revoke, suspend or otherwise restrict a license if the licensee has subverted or attempted to subvert any licensing examination or the administration of an examination.

Under Business and Professions Code section 490, the Board of Registered Nursing may suspend or revoke a license when it finds that the licensee been convicted of a crime.

4. Respondent has subjected her license to discipline under Business and Professions Code section 2761(d) in that she conspired to violate provisions of section 2797 of that code by arranging for Marilou Oro to impersonate Esmat Pira on April 19, 1988, in order take the examination for licensure as a vocational nurse for her at the Los Angeles Convention Center, Los Angeles, California.

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5. Respondent has subjected her license to discipline under Business and Professions Code section 496 in that she attempted to subvert a licensing examination by arranging for Marilou Oro to impersonate Esmat Pira on April 19, 1988, in order to take the examination for licensure as a vocational nurse for her at the Los Angeles Convention Center, Los Angeles, California.

6. Respondent has subjected her license to discipline under Business and Professions Code section 2761(f) in that on May 23, 1989, she was convicted by the Court on a plea of nolo contendere of violating provisions of Penal Code sections 182/134 (conspiracy to prepare false documents) in Los Angeles Superior Court, Central Criminal Branch, case number A973111, entitled People of the State of California v. Marianne Delapena Oro. Such conduct is substantially related to the qualifications, functions or duties of a registered nurse, as defined in Title 16, California Code of Regulations, section 1444.

7. Respondent has subjected her license to discipline under Business and Professions Code section 490 in that on May 23, 1989, she was convicted of a crime substantially related to the qualifications, functions or duties of a licensed vocational nurse, as alleged in paragraph 6.

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WHEREFORE, complainant prays that a hearing be held and that the Board of Registered Nursing make its order:

1. Revoking or suspending registered nurse license number E 424802, issued to Mariamne P. Oro.

2. Taking such other and further action as may be deemed proper and appropriate.

DATED: 11/21/87

CATHERINE M. PURI, R.N., Ph.D.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

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